

Primary Eye Care Provider: _____
 Location: _____
 Phone/FAX: _____
 Contact: _____

Asheville **eye**™ Associates

CONSULTATION REQUEST

Patient: _____ Age: ____ Date of Birth: _____ Date Referred: _____

Address: _____ Telephone: _____

City/State/Zip: _____

Chief Complaint: _____

Pertinent Refractive & Ocular History: _____

Meds/Dosages: _____ Allergies/Dosages: _____

Va _____ **Pinhole** _____ **J** _____ **Ta** _____ mm Hg
 _____ mm Hg
 sc cc _____ @ _____ am pm
W _____ Add: _____ **M** _____ 20/ _____ Add: _____
 _____ Add: _____ 20/ _____ Add: _____

Exam:	WNL	Other	Comments:
Pupils:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lids/Lashes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Conjunctiva	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cornea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Iris	<input type="checkbox"/>	<input type="checkbox"/>	_____
A/C	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lenses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fundus	<input type="checkbox"/>	<input type="checkbox"/>	_____

Assessment/Comments: _____

- Recommendation of Consultation for:**
- Cataract
 - Retina
 - Plastic
 - YAG Laser
 - Right Eye
 - Left Eye
 - Pediatric/Neuro
 - Multi-focal Lens
 - Glaucoma

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